

MDR Tracking Number: M2-03-1571-01
IRO Certificate# 5259

August 28, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in neurology. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

____ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ____.

CLINICAL HISTORY

A 37-year-old male with paravertebral muscle strain secondary to work-related motor vehicle accident on _____. Neurological exam nonfocal. MRI of the lumbar spine 2/11/03 showed mild disc bulge at L3/4 and very small annular tear at L3/4. Physical therapy was of benefit. ____ reports document very good improvement from the R S Medical R54i Sequential Stimulator 4-channel combination interferential and muscle stimulator beginning 1/10/03 with follow-up reports of 2/20/03 and 3/13/03 with decreased pain medication used, improvement in range of motion, and decrease in muscle spasm.

REQUESTED SERVICE (S)

Purchase of an R54i sequential stimulator 4-channel combination interferential and muscle stimulator unit

DECISION

Approve.

RATIONALE/BASIS FOR DECISION

____ reports document sustained improvement over two months as described above. Long-term use of stimulators is indeed appropriate for treatment of chronic pain, particularly with increasing range of motion and decreasing use of pain medication, and increased activities as reported by ____.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 29th day of August 2003.